

# Operation Transformation Contest

The Operation Transformation Contest is a 12-week competition starting in January 2010. Contestants will learn about and practice proper nutrition and exercise to transform their lives.

A grand prize will be awarded to the person who loses the greatest percentage of weight. Other prizes will be awarded.

The first step in the competition is having a resting metabolic rate test to determine the number of calories needed each day and then developing a diet. Contestants meet with a personal trainer or dietitian weekly to review nutrition logs, and learn nutrition tips and new recipes.

Exercise is the second step. Personal trainers lead two weekly group workouts, and participants also exercise on their own. Contestants will have full access to the land aerobics classes, aquatics classes and fitness gym at Great River Health Fitness. The third step is weekly meetings during which contestants discuss concerns about weight loss and management.

Contestants do not have to be Health Fitness members. Applications must include a written questionnaire and a five-minute video featuring applicants explaining why they should be chosen. Selection will be based on contestants' health concerns, such as high blood pressure, diabetes, and joint pain, and weight-related life concerns.

The application deadline is Monday, Jan. 4, 2010.

Fifteen contestants will be announced Friday, Jan. 8, 2010, on 107.3 KGRS, and they will be called.

For more information, please call Chris Reed, Great River Center for Rehab and Clinics, at (319) 768-4100.



## Operation Transformation Contest Application

**Applications must be accompanied by a five-minute video featuring you explaining why you should be chosen.**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Occupation \_\_\_\_\_ E-mail \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Weight (required) \_\_\_\_\_

What was your turning point that made you decide to enter the Operation Transformation contest? \_\_\_\_\_

\_\_\_\_\_

What weight-loss successes have you had? \_\_\_\_\_

\_\_\_\_\_

What would this way-of-life transformation mean to you? \_\_\_\_\_

\_\_\_\_\_

If chosen, what would be your 12-week goals? \_\_\_\_\_

\_\_\_\_\_

## Health History

Are you under the care of a physician?  Yes  No Date of last examination \_\_\_\_\_

If yes, please explain in detail \_\_\_\_\_

\_\_\_\_\_

Physician name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Are you taking any medicine?  Yes  No

If yes, please list name, dose and how often you take each \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke or use smokeless tobacco?  Yes  No

If yes, how long have you used and how much per day? \_\_\_\_\_

**Please check and, if applicable, date those that apply to you:**

- |  |            |   |            |
|--|------------|---|------------|
| <input type="checkbox"/> Anemia  | date _____ | <input type="checkbox"/> Hernia   | date _____ |
| <input type="checkbox"/> Angina  | date _____ | <input type="checkbox"/> High/low blood pressure                        | date _____ |
| <input type="checkbox"/> Angioplasty                                       | date _____ | <input type="checkbox"/> High <input type="checkbox"/> Low              |            |
| <input type="checkbox"/> Arthritis   | date _____ | <input type="checkbox"/> Injuries                                       | date _____ |
| <input type="checkbox"/> Back pain   | date _____ | Explain _____   |            |
| Explain _____  |            |   |            |
| <input type="checkbox"/> Blood transfusion                                 | date _____ | <input type="checkbox"/> Irregular heartbeat                            | date _____ |
| <input type="checkbox"/> Cancer  | date _____ | <input type="checkbox"/> Kidney disease                                 | date _____ |
| <input type="checkbox"/> Chronic cough                                     | date _____ | <input type="checkbox"/> Lung disease                                   | date _____ |
| <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive |            | <input type="checkbox"/> Operations                                     | date _____ |
| <input type="checkbox"/> Chronic headaches                                 | date _____ | Explain _____   |            |
| <input type="checkbox"/> Congestive heart failure                          | date _____ | <input type="checkbox"/> Pacemaker                                      | date _____ |
| <input type="checkbox"/> Coronary bypass surgery                           | date _____ | <input type="checkbox"/> Palpitations                                   | date _____ |
| <input type="checkbox"/> Coronary valve surgery                            | date _____ | <input type="checkbox"/> Rheumatic fever                                | date _____ |
| <input type="checkbox"/> Diabetes  | date _____ | <input type="checkbox"/> Seizures                                       | date _____ |
| <input type="checkbox"/> Diagnosed osteoporosis                            | date _____ | <input type="checkbox"/> Shortness of breath                            | date _____ |
| <input type="checkbox"/> Dizziness when rising or standing                 | date _____ | <input type="checkbox"/> At rest <input type="checkbox"/> With activity |            |
| <input type="checkbox"/> Dizziness, light-headedness                       | date _____ | <input type="checkbox"/> Swelling of the feet or ankles                 | date _____ |
| <input type="checkbox"/> Exercise or cold-induced chest pain               | date _____ | <input type="checkbox"/> Thyroid disorder                               | date _____ |
| <input type="checkbox"/> Gout  | date _____ | <input type="checkbox"/> Varicose veins                                 | date _____ |
| <input type="checkbox"/> Heart attack                                      | date _____ | <input type="checkbox"/> Other  | date _____ |
| <input type="checkbox"/> Heart murmur                                      | date _____ | Explain _____   |            |

## Family History

If you do not know your biological family's health history, leave this section blank and go to Way-of-Life History.

Is your father living?  Yes  No Age at death \_\_\_\_\_

If no, what was the cause of death? \_\_\_\_\_

If yes, how old is he? \_\_\_\_\_

Please list his medical problems \_\_\_\_\_

Is your mother living?  Yes  No Age at death \_\_\_\_\_

If no, what was the cause of death? \_\_\_\_\_

If yes, how old is she? \_\_\_\_\_

Please list her medical problems \_\_\_\_\_

Please check here if there is a family (parents, grandparents, siblings) history of:

- | Relationship                                 | Relationship                                       |
|--|--|
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Diabetes _____      | <input type="checkbox"/> Stroke _____              |
| <input type="checkbox"/> Heart disease _____ |  |

### Way-of-Life History

How many days a week do you exercise? \_\_\_\_\_

How long (minutes) does a typical session last? \_\_\_\_\_

What types of exercise do you enjoy?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Aerobics classes   | <input type="checkbox"/> Jogging/running | <input type="checkbox"/> Stair climber   | <input type="checkbox"/> Treadmill running |
| <input type="checkbox"/> Cross-training     | <input type="checkbox"/> Plyometrics     | <input type="checkbox"/> Stationary bike | <input type="checkbox"/> Walking           |
| <input type="checkbox"/> Dynamic stretching | <input type="checkbox"/> Pool exercise   | <input type="checkbox"/> Swimming        | <input type="checkbox"/> Weight training   |
| <input type="checkbox"/> Elliptical trainer | <input type="checkbox"/> Road bike       | <input type="checkbox"/> Track workouts  | <input type="checkbox"/> Yoga/Pilates      |
| <input type="checkbox"/> Free weights       | <input type="checkbox"/> Rowing machine  | <input type="checkbox"/> Trail running   |  |

Are you on a special diet?  Yes  No If yes, please explain \_\_\_\_\_

Is stress a concern now?  Yes  No If yes, please explain \_\_\_\_\_

I have reviewed and answered each question. I approve the release of this information to my primary physician(s) if chosen as one of 15 Operation Transformation contestants. Information will not be released without my written consent, but the questionnaire information may be used for statistical or scientific studies with my right of privacy retained.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

OFFICE ONLY

Operation Transformation Contest application notes \_\_\_\_\_

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